DOCUMENT RESUME

ED 424 620 EA 029 382

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TITLE Principals, School Nurses and Other Health Care Providers: An Introduction.
PUB DATE 1998-00-00
NOTE 51p.
PUB TYPE Reports - Research (143)
EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS *Administrator Attitudes; Adolescents; *Child Health; Children; Elementary Education; Medical Care Evaluation; *Principals; Pupil Personnel Services; *School Health Services; *School Nurses
IDENTIFIERS *Elementary Secondary Education Act Title I

ABSTRACT

It has become increasingly important to collect information on the health care problems of students in Title 1 public schools. Information to help fill this need is provided here. The study opens with a discussion of children's and adolescents' health care needs. It describes how health care in public schools is delivered on a national level, focusing on a particular K-8 Title 1 public school district in the Southwest United States as a representative district. The report provides information on the health-related problems experienced by Title 1 students and gives information on the preparedness of school administrators to assist providers in delivering needed health-care services. The findings indicate that principals and health care providers correlate students' health with students' likely success in school, that principals find it necessary to provide and to assist in providing health care at their sites, and that the principals interviewed were knowledgeable of the health-care problems experienced by their students. Findings also indicate that the capacity of administrators to provide help on health-care-related issues was weak, that health-care staff were underutilized, and that administrators and health-care providers differed in their orientation to health-care delivery. Questions regarding accountability, ethical issues, and other concerns are raised. (Contains 35 references.) (RJM)

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Principals, School Nurses and Other Health Care Providers: An Introduction

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Abstract

This study opens with a discussion on the health care needs of children and adolescents in the United States. Then it describes how health care in public schools is delivered on a national level and in a particular K-8 Title 1 public school district in the Southwest. This study also provides information on the health related problems experienced by Title 1 students, and information on the preparedness of school administrators to assist providers in delivering needed health care services. Findings taken from this study indicate that administrators and health care providers associate the health of students with their likely success in school, that administrators find it necessary to provide and to assist in providing health care in their sites, and that the administrators interviewed were knowledgeable of the health care problems experienced by their students. Findings also indicate that the capacity of administrators to provide help on health care related issues was weak, that health care staff were underutilized, and that administrators and health care providers differed in their orientation to health care delivery. These findings raise concerns about how public schools limit the quality of health care provided to needy students and families. In addition, findings raise doubts about the effectiveness of existing school policies and practices for promoting health care approaches that stress prevention. Finally, results taken from this study raise questions related to accountability, ethical questions and questions on how public schools may limit opportunities for students to learn by adopting policies and procedures that impede the delivery of quality health care.

and that sustain and possibly exacerbate the health problems experienced by students enrolled in their Title 1 schools.

Introduction and Issues to Be Addressed

The argument against delivering health care to needy students in public schools has been weakened by a number of powerful and related developments. First, acceptance of the concept and practice of inclusion is growing in momentum (Bartlett et. al., 1994; O'Brien, Snow, Forrest and Hasbury, 1989; Stainback and Stainback, 1990). When combined with progress in medical intervention, this concept has allowed more children with health related problems to return to school and to join more quickly in learning in public school settings (Lehr and McDaid, 1993).

Second, participation in public schools by children with health related problems and disabilities is supported by existing federal legislation. Section 504 of the *Rehabilitation Act of 1973* prohibits discrimination against individuals with disabilities who also receive health care services in public schools. This Act mandates that needy children be provided the opportunity to participate in federally funded programs. In addition, the *Americans with Disabilities Act* of 1990, the *Individuals with Disabilities Education Act* of 1990, and Title XI, P.L. - 103-382 of the Secondary Education Act, as amended by the *Improving America's School Act* of 1994 each ensure the rights of children with disabilities and health related problems to receive a free and appropriate public education.

Third, research has shown that the physical and psychological health of children have a direct impact on their abilities to succeed academically and socially in school (Bush, 1997; Jang, 1994; Passarelli, 1994). In particular, it is generally recognized that the conditions of poverty, emotional and psychological distress, child abuse, poor nutrition, disease, inadequate preventative and health maintenance practices and that

other such preventable morbidities have conspired to weaken students and to imperil their academic success and their success in the future.

Fourth, research indicates specific students in the United States are currently experiencing some health related problems at higher rates than in the past (Allensworth, 1993; American School Health Association, 1989; Hacker, et al., 1994; Lavin, Shapiro and Weill, 1992). This research suggests that as the complexity of their needs in the past decade has increased, so too has the complexity of demands being placed upon public schools to anticipate, plan and provide for these children (Bartlett, 1994).

For example, research indicates that since 1975 the numbers of children living in poverty have doubled (Simpson, et. al., 1997). In 1996, the U.S Department of Health and Human Services reported that at least 1 in 20 – or as many as 3 million children and youth – may have a serious emotional disturbance (U.S Department of Health and Human Services, 1996). Child abuse has risen to greater than 850,000 substantiated cases a year, teen suicides have nearly doubled since 1970 and teen homicides have also been found to have almost doubled in the past decade alone (Simpson, et. al., 1997).

In addition, rates of respiratory problems for children and youth have increased dramatically since 1990 while immunization rates have remained below recommended guidelines (U.S Department of Health and Human Services, 1996). Leading reports on the health of children and youth completed during the 1990s also revealed that while their overall health status did not differ according to age or gender, the health status of young people did differ along demographic and economic lines for certain subgroups of the population (Coiro et. al., 1994; Newacheck, et. al., 1994; Simpson, et. al., 1997; U.S Department of Health and Human Services, 1996). In particular, findings indicated that

differences in the proportion of children reported to be in excellent health emerged when comparisons were made across race and ethnicity. Smaller proportions of minority children received favorable health ratings than either White or Asian children from their parents and guardians for example (Coiro et. al., 1994). These young people -- ages 0 to 17 years -- also experienced a greater variety and more severe health problems, and they experienced more frequent and longer periods of time when they were inactive, bedridden, and absent from school than their White peers (Coiro et. al., 1994).

Findings taken from these different reports also indicated that children's overall health ratings and their access to health care were strongly associated with the income levels of their parents. Findings showed that 64 percent of children from upper income families were rated by parents and health care providers in 1990 as being in excellent health as compared with 35 percent of low income children nationally (Coiro et. al., 1994; Simpson, et. al., 1997; U.S Department of Health and Human Services, 1996). Findings taken from analyses of government reports also revealed that poor children and youth were two to three times as likely as non poor children to have experienced health problems that limited their activity and rates of attendance in school (Starfield, 1992).

Data compiled by researchers working for the U.S. Department of Health and Human Services also revealed that in 1993 parents of over 7 million youth 0 to 17 years of age reported having difficulty obtaining needed medical attention for their children (Simpson, et. al., 1997). According to these parents, having no money to afford health insurance and having no transportation were two key factors in children going without medical care, dental care, prescription medicine and glasses. In particular, an estimated 45 percent of children in families with an annual income of less than $20,000 experienced

difficulty in having their health needs addressed (Simpson, et. al., 1997). Findings taken from other research similarly indicated that poor children were more likely to experience short term restriction of activity due to acute health problems (Igoe and Giodano, 1992; Justice, 1988; Office of Technology Assessment, 1988; National Center for Education Statistics, 1992), that they had 32% more restricted activity days, 78% more bed days, and 55% more school absence days than children from non poor families (Newacheck, Jameson, and Halfon, 1994). Indeed, the American Medical Association declared an "health crisis" in 1992, proclaiming that "for the first time in the history of this country, young people are less healthy and less prepared to take their places in society than were their parents" (Cohen, 1992, p. 126).

Finally, results taken from research on the needs that educators have related to assessing and caring for students with poor health revealed that teachers often feel unprepared to assist students with health related problems. These findings indicated that a lack of information existed about the specific health problems that children experienced as they related to their classroom adaptation, school policies concerning medication, and the involvement of children with health problems in physical education activities (Johnson, Lubker, and Fowler, 1988).

Previous studies on children with terminal illnesses similarly indicated that teachers desired more information about the health condition and about the expectations held for the child in the school environment (Eiser, 1980; Klopovich, Vats and Cairns, 1981). Research on the perceptions of parents also revealed they felt teachers did not understand and adequately respond to the health related needs of their children (Freudenberg, Feldman, and Millman, 1980). Findings taken from other studies similarly

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indicated that one in five teachers were unaware of the health condition and medical needs of students in their classrooms and that more than 45% of teachers surveyed requested more information about the health of their students (Fowler, Johnson and Atkinson, 1985; Lubker, Simeonsson, 1986).

Upon combining findings from reports on the health of our nation's children with the other concerns raised, it becomes increasingly important to collect information on the health care problems experienced by students in Title 1 public schools and to examine how health care is delivered to those students in their schools. Studying approaches to health care delivery is also important for understanding how administrators, school nurses and other health care providers interrelate, and for understanding the roles and responsibilities that these different individuals assume. Studying health care is also important for understanding policy and practice and the context and school governance structures within which Title 1 school health care providers operate. In addition, studying health care delivery in Title 1 public schools is important for identifying barriers to access, and for assessing the readiness of principals in Title 1 schools to assist in addressing the health care needs of students from low income backgrounds.

Health Care Systems in Public Schools: A Model of Health Service Delivery

School-based clinics have been identified in the research as the most widely used approach for delivering health care to students in public schools (Passarelli, 1994). School-based clinics tend to be headed by registered or licensed practical nurses. This nurse provides health services for children and youth with acute, chronic, episodic and emergency health care needs and problems (Miller and Hopp, 1988; Passarelli, 1994). The school nurse also screens the health status of students, identifies health problems

which may hamper a student's educational progress and develops a health care plan for maintaining a safe and healthy school environment (Fryer and Igoe, 1996). The school nurse also intervenes in medical emergencies, administers medication, performs special health care procedures, delivers health care to disabled students and provides health education and counseling for students, families and school personnel (Lear, Montgomery, Schlitt and Rickett, 1996).

On average, research indicates that one school nurse is available to provide health care services to more than 800 children, youth and school personnel in a single public school setting (Igoe and Giordano, 1992). In a larger urban school district that ratio may exceed 1000 to 1 with the average number of registered nurses employed in a district frequently not keeping up proportionately with an increase in size of the student population (Igoe and Campos, 1991). In response to growing student populations, (Igoe and Giordano, 1992), to concerns for saving money (Fryer and Igoe, 1996) and to the many forces eroding the health of children and families (Johnson, Lubker, and Fowler, 1988), school health systems have been redesigned to involve others in providing health care. Today, school-based clinic staff members typically include a school nurse, an health assistant, part-time physicians, social workers and a school psychologist who assist, in varying degrees, in providing primary health and mental health care services to different students and adults in public schools.

Recent research indicates for instance, health assistants are becoming more involved in administering health care services in public schools (Fryer and Igoe, 1996). These assistants are usually employed by the public school district and include unlicensed clerks and paraprofessionals for whom school health care responsibilities are secondary to

other responsibilities. They also tend to be assigned more basic tasks including administering first aid and medication to students and are reportedly not being used to supplant more expensive nurses and other health care personnel (Fryer and Igoe, 1996). Health care assistants are usually supervised by school nurses and other trained health care staff when administering health care to students (Lear, Montgomery, Schlitt and Rickett, 1996). Their performance has been rated very highly by school nurses, principals and school personnel suggesting that the expansion of their responsibilities may be imminent (Fryer and Igoe, 1996). On the other hand, additional findings taken from these recent research indicate that a moderately higher rate of lawsuits over care delivered by health assistants may be deterring the more aggressive use of their services in public schools (Fryer and Igoe, 1996; Lear, Montgomery, Schlitt and Rickett, 1996). School nurses, on the other hand, are most often supervised by principals and educational administrators with little to no medical training and experience (Fryer and Igoe, 1996; Igoe and Campos, 1991; Igoe and Giordano, 1992).

The Title 1 schools and school district included in this study relied almost exclusively on school-based clinics for delivering health care to their low SES students over the course of this two year investigation. Hence, other forms of health service delivery like family health centers and centers that actually link schools and community health providers are not reviewed and discussed. Instead, more information on the specific objectives of this research, on the Title 1 school district, on the schools and the participants who were included in this study are provided. The assumption made while collecting data for this study was that the development of students with low income backgrounds depends not only upon educational programs but also upon programs that

nurture and deliver quality health care to these students. Health programs in schools sustain the physical, psychological and emotional well-being of children and thus contribute in great measure to their overall cognitive and social development. Data was also gathered with the assumption that health care policies and procedures can be deliberately created, maintained and improved through specific approaches to leadership, management and organizational reform (Bryce, Lee, and Smithy, 1990; Newmann, et. al., 1989; Rosenholtz, 1989; Little, 1982).

Objectives of the Research

Four objectives guided this research. First, interviews were conducted to assess the extent to which principals in Title 1 schools were knowledgeable of the health problems experienced by students in their schools. The second objective related to examining how principals responded to these health problems. The third objective involved collecting information on the instruction that principals received in their administrator preparation programs and assessing how that training addressed health care and the improving of health care delivery to students in schools. The fourth objective related to assessing the extent to which the policies and procedures followed in a Title 1 public school district in the Southwest enhanced and limited health care delivery to needy students.

Data collection protocols were developed for interviewing principals and for observing their behaviors. These protocols were also used for collecting and studying district policy and school documentation. All of the protocols used for this study included similar questions and probes that related to the four objectives described earlier. The *Ad Hoc Task Force's Position Paper on School Nursing Services in Arizona* (1992),

a publication of the Arizona School Nurse Organization, and *The Health Needs of Arizona's Women, Children and Adolescents* (1996), a statewide assessment designed by members of the Arizona Department of Health Services to help Arizona anticipate and meet the health care needs of families, served as the standards in developing the data collection instruments. Principals, school nurses, health care providers and policy analysts from the Arizona Department of Health Services also contributed by making additional suggestions on instrumentation, interview schedules and by offering recommendations on methods of data collection and analysis.

Background Information and Participants

The individuals included in this research all work in the Raven Elementary Public School District. This school district is located in Maryvale County, a county that has grown more than any other in the United States in both the past year and in the seven years since the last census was released (U.S. Census, 1998). According to recent state census figures released on March 17, 1998, for example, Maryvale County gained 82,789 people from July 1, 1996 to July 1, 1997. In the seven years since the 1990 census, the population of Maryvale County has grown more than 27 percent, from 2.1 million to 2.7 million inhabitants.

These newcomers to Maryvale County are generally of working age and have moved from the Midwest and other states. In addition, the birthrate in Maryvale County is more than twice its death rate and 6,256 immigrants arrived from other countries during that same year. These developments are significant because of their accelerated rate and due to their enormity. In addition, these trends are significant because domestic and international immigration, and a greater number of births than deaths constitute the

three major contributors to population growth. Finally, these population shifts are critically important for understanding recent demographic trends and for understanding the emergent health care requirements experienced by low SES students in the Raven Elementary School District.

Like the State and Maryvale County, the Raven Elementary School District has experienced major demographic and economic transformations since 1990. Located in a low income community in the inner city in the Southwest region of Maryvale County, the Raven Elementary School District covers a 6.12 square mile area with 7,856 students enrolled in preschool through grade 8. Since the 1989-1990 school year, enrollment in this district has increased by 42 percent. The numbers of Limited English Proficiency (LEP) students has also risen from 1,137 students in 1990 to 3,124 students in 1996. These figures represent an 175 percent increase in the numbers of LEP students enrolled making Raven a majority minority elementary school district in terms of the racial and ethnic background of its students. In addition, the numbers of students receiving free and reduced lunches has grown from 3,168 to 6,136 representing a 94 percent increase from 1990 to 1996. These trends have made the Raven Elementary School eligible to receive different types of support and federal appropriations. These trends and Title 1 reforms have also contributed to Raven's reclassification as a Title 1 public school district.

All together, Raven Elementary School District personnel number over 700 administrators, teachers and staff members. Raven is made up of one preschool, one K-3 school, five K-6 schools, one junior high school for grades 7-8, and one alternative school for grades 7-8. The junior high school principal also oversees the alternative school

which is housed at his school site. The preschool is led by a former principal who is classified as the preschool director.

In total, seven principals and one preschool director supervise the nurses and the other health care providers in the Raven Elementary School District. The practice of using principals and other school administrators to supervise nurses and other health care staff, as noted, is not unusual and particular to Title 1 schools or the Raven Elementary School District. In fact, research indicates that school nurses are typically supervised by a non health care professional and that principals and other administrators supervise school nurses in most public school districts in the United States (Fryer and Igoe, 1996; Igoe and Campos, 1991; Igoe and Giordano, 1992).

The individuals interviewed and observed during this study included one Associate Superintendent who agreed to allow me to conduct this research, the seven principals and the one preschool director mentioned earlier who supervise and formally evaluate the school nurses and other health care staff. Twenty health care providers employed by the Raven Elementary Public School District were also interviewed and observed. These health care providers included eight registered nurses, eight health care assistants, two social workers and two school psychologists. These individuals provided primary health and mental health care services to students and school personnel. They were also supervised by the District's Associate Superintendent and were involved in different health care and non health care related activities.

Table 1 lists the major tasks required of the school nurse and of the other health care providers working in the Raven Elementary Public School District. This list comes from data generated through interviews and observations of school nurses and health care

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staff, from the position description approved by the school district's Associate Superintendent and is not inclusive of the range of activities in which the nurses and other health care providers were involved. These administrators, nurses and health care providers were included in this research to assess the extent to which principals were knowledgeable of the health problems experienced by students, to learn how they responded and were prepared to respond to their students' health problems, and to learn about the extent to which the policies and procedures adopted by the principals and district enhanced and impeded health care delivery for needy students.

Table 1. Major Responsibilities of the School Nurse and Health Care Providers.

1. Organizes and arranges for health screening and assists in registration of kindergarten students.
2. Participates in the referral and evaluation process for placement of special education students.
3. Identifies health needs of students and school personnel.
4. Provides health counseling.
5. Maintains health and accident records.
6. Cooperates with school, home, community and paraprofessionals in the health field in developing programs and communicating related information.
7. Provides follow-up with parents of non-attending students.
8. Processes tardy students.
9. Conducts school bus evacuation drills.
10. Conducts human growth program.
11. Dispenses medication to students.
12. Maintains immunization records of students.
13. Provides special care for handicapped students.
14. Supervises health related paraprofessionals, if necessary, when on the same site.
15. Performs other tasks as required to accomplish the District mission, goals, and objectives as assigned by their direct supervisor or by the Associate Superintendent.

Methodology and Data Analysis

To understand health care delivery in Title 1 schools, qualitative methods were developed. Unstructured interviews were used first to amass a breadth of information on which individuals to include in this study, on which district policies to study, and on which school procedures and health care services were being provided. Unstructured interviews were also used to assess the levels at which participants understood and claimed to understand each other, to establish a balanced rapport, and to reduce the potential for respondents to draw assumptions from the researcher or according to the nature of the questions asked.

After I transcribed and organized the information collected through unstructured interviews into six three ring binders, participants were separated into four focus groups to handle and to become familiar with the data. One focus group included five principals and the preschool director while a second included seven school nurses. A third group was made-up of five nurse's assistants and the fourth focus group included two social workers and two school psychologists. Forming these four focus groups was important for stimulating discussion and for strengthening rapport among the administrators and different health care providers in the eight schools in the district. Having the focus groups meet early in district office and three more times over the course of this study was also useful for (a) reviewing the purpose of the study, (b) for assessing, organizing and analyzing the data collected and stored in the three ring binders, (c) for gaining assistance, support and recommendations on additional data sources, definitions, services and methodological techniques to use for future data collection and analysis, (d) for pre-

testing questions and developing structured interview protocols, and (e) for triangulating data and getting a more holistic and representative view of health care delivery in the Raven Elementary School District as described by district personnel.

Structured interviews were also used during this research. These interviews were recorded and each participant was asked to respond to the same set of questions and probes presented in the same order. These queries were developed after studying research on school nurses and health care delivery in schools, after reviewing state and school district health care policies, after pouring over data contained in the binders, and after having focus group participants provide their recommendations on the readability, relevance and comprehensiveness of the protocol instrument used to complete the structured interviews. Participants were then provided with a copy of the interview protocol, scheduled, and interviewed one-to-one in their schools, in space available at district office and in the homes of two of the participants.

Structured interviews were used here to stimulate additional conversation and frankness in responding assuming that some participants preferred one-to-one interaction (and that the questions included on the interview protocol were phrased correctly). Structured interviews were also used to understand the social interaction context and to assess how the responses given by interviewees may have been influenced by their surroundings (Fontana and Frey, 1994). Finally, structured interviews were used as an alternative methodological technique for collecting additional data for later analysis.

Questions asked of respondents elicited personal views, understandings on participants' social and interpersonal relationships, perceptions about health service delivery systems and perceptions related to the support provided to personnel working in

those systems. Participants were also asked to recall what they experienced and understood generally about the health care needs of the students enrolled in their schools. They were asked to tell, as best they could, about how individuals and groups supported and/or limited access and health care delivery to needy students. Participants were also asked to describe how policy, school practices and programs, and district procedures supported and/or limited access and health care delivery to students in their schools.

The interviews with participants tended to progress from open to more direct questions. Principals, school nurses and the other health care providers were assured their responses would not be associated with their names, with their peers or with the schools with which they held affiliations, and that no harm would come to them through involvement in the study. This seemed to help the educators and health care participants to be forthcoming and honest with their assertions. They seemed willing to describe their feelings, experiences and behaviors, and to provide rationales for what they recalled, believed and did. Focus group sessions last from 25 minutes to one and one quarter hours. Structured interviews ranged from 35 minutes to two hours in length. Each interview session was taped and transcribed.

Eleven themes were developed during the different interview phases, during participant observations and during document analyses. Constant comparison was used to derive these themes from the data (Glaser and Strauss, 1966). This data was also coded and three categories became apparent from the analysis of this coded data. One category described the perceptions that principals and others held regarding the health problems experienced by students and how they responded to these problems in their schools. The second category housed assertions on the preparation principals received for

furthering health care delivery in their schools. The third category emerged during analyses of the data. It related to how the policies and procedures adopted in Title 1 schools studied supported and limited the delivery of health care to needy students.

The process of data analysis and for developing categories began with multiple readings of the entire data set. Three copies of transcript data were made available to and analyzed independently by the principal investigator and by two other trained analysts. These three individuals searched for key elements, themes and categories within the data to both test and to isolate those categories which made the largest number of connections to items in the entire data set. These procedures and the constant comparison of data were carried on in an ongoing and pulsating manner. Emerging themes and categories were also brought into sharper focus by accounting for additional negative cases, by asking additional direct questions, by checking and rechecking the stories told by administrators and care providers individually and as they were organized in their focus groups, and by following up on additional leads. Participants were also asked to read, edit and to verify the categories developed which dealt with providing health care to students in their schools. Finally, the principals and health care providers were asked to rate the credibility of theirs and the accounts of others. They were asked to discuss and to judge the accuracy of themes, concepts, and the categories developed given their participation in the study and the influence of their peers, the school setting and the researcher.

Then, assertions made by the participants that were repeated often and that were taken from each of the data sources were judged by the research to be the most reliable for developing and labeling categories. These categories were, once again, examined by

the researcher, analysts and participants in focus groups to account for patterns found across frequent and rare events, to account for similarities and differences across confirming and disconfirming evidence (Bogdan and Biklen, 1992; Glesne and Peshkin, 1992), and to add validity to the conclusions drawn from analyzing the data .

The three categories that survived the different analysis are framed by the research questions and introduced in the discussion section of this research. To understand the logic and to establish the validity of these three categories, excerpts taken from the body of information are provided in the section labeled "findings." These excerpts are also provided to maintain the integrity and voice of the participants and to enable readers to form their own interpretations (Capper, 1994). Quotations taken from the data set are also provided to confirm, by using participants' own words, the importance of their ideas, experiences and views on providing health care to needy students in public schools.

Findings

Each of the principals, school nurses and health care providers interviewed for this study agreed that the health of their students related to how they behaved and to their academic progress in school. The principals and the preschool director differed slightly in their perceptions on the actual health care problems experienced by their students. Each of these participants was critical of the preparation of school administrators, and principals and health care staff also disagreed on the purposes and the best procedures for health care delivery.

On the Health Problems of Students

The seven principals and the preschool director believed that students suffered most often from respiratory problems. They also believed that their students experienced

poor health and poor physical development, and that these conditions were due to poor nutrition, an unbalanced diet, inner ear infections, vision and dental problems. The administrators interviewed also indicated that students had problems with personal hygiene.

Responses provided by the school nurses, the two psychologists, the two social workers and the other care providers agreed with those made by the principals and the preschool director although the descriptions made by health care staff also focused upon the psychological and emotional distress experienced by students. The health care providers also listed accidents, child neglect, substance abuse and sexual activity as factors contributing to the poor health of students overall. Finally, administrators adopted health care approaches that "responded" to the needs students while health care providers classified the health problems experienced by students as "preventable."

Reasons given for the health care problems experienced by students were associated by both the administrators and health care providers with the poor overall health of students, with the unstable and disabling characteristics of their families, and with their dysfunctional community environment. Participants also identified the depressed economic backgrounds of students as contributing to the poor health of students.

Administrators

Respiratory Problems

When asked to name and to talk about the health problems experienced most frequently by their students, the principals and director agreed that "many [students] have asthma," "respiratory," "breathing," "bronchial," and "breathing type problems." One

administrator said she knew this as "students could pick-up their inhalers and their other medicine from the office whenever they needed." She added that there were "five or six kids who you see in the office who regularly have problems with breathing."

Another administrator said "we have a list of names with students whose participation in physical education is forgiven because they get too excited, they can't breath and they need to stop and sit down for a period of time." A third explained that "district policy requires us to account for classes missed due to illness in school and legal absences [and] to identify reasons why they miss time in class." A fourth principal recalled having had "allergies" and "asthma as a child." She said she could "tell when a student is experiencing really serious problems with breathing." This principal remembered "counsel[ing a teacher] to recognize when students are having difficulty [breathing]." She explained that:

> "I just happened to be leaving... no responding to a disturbance when I observed one of the teachers getting her students in order. They had just returned from some sort of physical activity outdoors when I noticed one student bent over at the waist with his hands grabbing hold tightly of his knees. The other students lined up and crowded around him and he was wheezing, drawing in air in long drawn breaths. I waited a moment then put my arm around his shoulder and escorted him into my chair. At that point there's little you can do. You should never administer Salafolin, Primateen or one of those other over the counter drugs because the child's condition could be situational brought on by an allergic reaction or physical stress. The best thing, in this case, was to calm the boy, to convince him to relax and to get him to try to breath regularly through his nose. I

had the nurse paged and she's really very good about coming quickly and taking care of these things and following up with parents without any fuss. I don't know where we would be without having her on staff here every day. "

Still commenting on the respiratory problems experienced by their students, the principals took turns responding, adding that students routinely had "coughs," "runny noses," "those deep hacking coughs" and that "there are always colds running around in our building." These administrators also agreed that "respiratory ailments," "respiratory problems," "breathing problems" and "sick with problems with their breathing" was the most common reason for the preschool to grade eight students to be absent from school.

Poor Diet and Slower Physical Development

The second most common explanation given by administrators on the health problems and absence of students from schooling related to the "poor health of students overall," to their "poor diet" and "poor nutrition," and to the students "slower physical development rate." When asked to explain, the principals and director commented that "many [students] just seem weaker all the time because they don't get the right foods to eat," "are weaker," "not as strong as they should be," that students "have poor nutrition and are in poorer physical health in general," and that their students "aren't big like others in their peer group."

One administrator commented that "their slower development becomes obvious when they compete against students from other districts." She recalled observing during an after-school sporting event that:

"Our students probably didn't really have a chance of winning. They were smaller than the other school's students were across the board. Every one of those

students seemed stronger and more mature physically too if you know what I mean. They ran faster, jumped... it was like they got every shot we missed and they missed and then they would put the ball back in and score. The game was over by after 15 or 20 minutes maybe. I felt so bad because our students tried so hard to play but they were just overmatched. Then the other team's coach started putting in his other players and it hardly made a difference. The game just went on and on like it would never end. We try to give recognition to our students for getting involved and competing and trying their best in school and basketball and other events. We don't overemphasize winning but you can see many of them are disappointed when they're finished playing. It's a credit that they come back every year to practice and try for the team."

Commenting on the behaviors of students during breakfast and lunch, another administrator added that:

"At first I would get annoyed at [the students] for all the food that was wasted. We would see them eating the cereal and the desert type foods, but never the fruits and vegetables, the sandwiches and warm meals. The apples and oranges were always going in the garbage. The sandwiches and spaghetti and other food wrapped in the aluminum foil... always the same thing. It's perfectly good food that we serve, I've had it but I don't understand why they don't eat it. One of the lunch aids thought it was because the kids go for the sugar... that they like eating sugar and don't usually get the food we serve when they eat dinner at home. It's no wonder so many get sick so often and that their resistance is nil."

Other administrators described having similar experiences. One admitted "sav[ing] the apples and oranges until district office got hold of it." Another nodded and explained that "policy says the food is to be eaten by the students in school and that we can't recycle it or even give it away if we wanted to." A third administrator said she believed that "the students diets don't match." She explained that "whatever they eat at home is probably different from what they can get in school to eat." When asked to explain further, this administrator admitted she "can't say for certain but it just seems they don't have a taste for many things, especially what we serve in school."

Another administrator added she was aware "the grocery lets our parents exchange their coupons so they can get more for their dollar." According to this administrator, "what happens is the store owner thinks he's really helping the parents buy more things when he really doesn't do any good because our families don't buy the right food and they don't get a balanced diet." Asked how she could be certain, this administrator recalled "meeting with [the store owner] to talk about keeping the store closed and to stop selling candy to our students in the morning when I was waiting and could see what was happening." This administrator explained that "[the store owner] was letting [the parents] buy [inexpensive] things so they could use the money and extra change they had left over to get other things for the family that they really needed." "Fruit, milk and vegetables takes a back seat when our parents shop for what their kids will eat sometimes." This administrator added, "that may explain why the students have lousy diets, and why they have a hard time keeping up like they should."

Sensory-Related Problems

A third set of "sensory-related" health problems, according to administrators, were being experienced frequently by students. These problems included "ear infections," "problems with their teeth," and "many of our students needing glasses." Each of the administrators interviewed recalled working with "parents" and "students' families" to address these conditions and to get assistance. These administrators described turning to "the Lion's Club," "a community health clinic," "friends," "the [neighborhood] church" and "private donations from friends" for transportation and medical and financial support. Nearly all remembered providing "transportation," "car rides," and "rides for students" with "earaches," "some sort of pain with [their] teeth," "a toothache," and "fluid in their ears." One administrator recalled "driving Clara, a third grader, her mom and her two younger brothers for eye exams and then taking them to get glasses during a couple of weekends."

When asked how often they participated, each administrator admitted they were involved "in some way or another" "everyday" or "on every school day" in issues related to providing for the health care of students. These principals and the director agreed that "it's a given," "you plan to expect it," and that they "take it for granted" that "kids get sick everyday and you're going to be called on to help." One administrator said she "carr[ied] Kleenex in [her] sleeve." Another chuckled and said "I carry band aids in my pockets." A third administrator described "sitting on the brown couch in the nurse's office" and "just talk[ing] and listen[ing] to see how [the students] are doing everyday." A fourth commented that "It's amazing, but unless you think about it, you just don't

realize how many students you meet when you're wiping noses and bandaging hands and knees."

Poor Hygiene:

Students with "poor hygiene" and "poor personal care habits," according to the principals and the preschool director, "[did] not bathe regularly," "smell[ed] bad," "[had] a strong unpleasant odor," "look unkempt," had "problems with their skin," "lice" and "[wore] the same unclean clothing nearly all the time." Recalling students enrolled in their schools, one administrator described a youth that "always looked like he fell right out of bed, got on the bus and came to school in the same clothes he wore the night before." Another commented that "going to his home, talking with his parents, nothing made a difference. [The student] smelled so terrible I finally had him take a shower in school." These administrators also described "tak[ing] the time" and "mak[ing] an effort" to "take different students for haircuts," "emphasize taking care of yourself and your body" and to "supervise," "counsel," "teach" and "help" students "wash," "wash up," "clean themselves," "clean and brush their hair," "brush their teeth" and "wash their faces and hands." One administrator also described "two brothers and a sister from the same family [having] lice in their hair 3 or 4 times already this year."

Health Care Providers

As mentioned previously, the school nurses, psychologists, social workers and other health care providers identified the same health problems as the principals and preschool director. These individuals commented that students most often suffered with "asthma," "breathing problems," "difficulty breathing," "bronchitis," and "respiratory ailments." Like the administrators, they also identified "poor diet" and "poor nutrition

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habits" as contributing to the "underdevelopment," "reduced growth" and the "undersize" of students. These health care providers also commented that a "large number," "large proportion," "many," "about 30 percent" of students suffered from "ear infections," "obstructed hearing" and "problems related to [students] teeth," and that they "take care of hygiene problems" routinely.

In addition to the views that they shared with the administrators interviewed, the nurses, psychologists, social workers and other health care providers also identified "accidents," "neglect," "child neglect," "substance abuse," and "students experimenting with sex" as factors placing students at risk.

Accidents, Child Neglect, Substance Abuse, and Sexual Activity: Risk Taking Behaviors

"Accidents," "child neglect," "substance abuse" and "experimenting with sex" described an additional set of morbidities or "risk taking behaviors" that led to students experiencing health related problems and "being at risk" of "illness," "compromised health" and of "missing school days" according to health care staff. The school nurses, psychologists, social workers and other care providers reported "a lack of adult supervision" and "inadequate parenting skills" as leading students to experience "bodily harm," "risk taking behaviors," "injuries with friends," "automobile related injuries," "cuts," "abrasions," "lacerations and broken bones." Health care providers also listed "family problems," "family turmoil," "sudden changes in family structure," "family upheaval," "divorce," "an unstable home environment," and "[students] not having a father at home" as "some of the main things" that contributed to students experiencing

"neglect," "being neglected" "[students being] ignored at home" and "improperly cared for by their parents."

The health care providers also commented that having "two parents," "the same two parents at home all the time," "ground rules," "rules that are consistent and that parents enforce," "a grandparent or responsible adult who was also dependable," "family discipline" and "a predictable home life" as "mak[ing] a big difference in the number of accidents and neglect cases we get in the district each year." These individuals also listed "spousal abuse," "alcoholism," "one of the parents –especially the mother-- being into alcohol or drugs," "unsafe neighborhoods," "gangs," "gang activities," "not having a safe quiet place to go," "pressure from the neighborhood," "pressure from peers," "crime," "violence," "being poor," "not being able to afford things," "not having things" and "poverty" as contributing to students "getting hurt," "finding drugs," "getting in trouble," "[being] unhealthy psychologically and emotionally," to students being "depressed," "sad," "[experiencing] emotional and psychological pain," "to their being alienated," and to students feeling "low self concept," "empty," "out of sorts" and "all on their own."

One school nurse explained "when you see those students who have experienced neglect or especially some upheaval or some range of family problems at home, you can tell. You can just tell. You see emotions, the pain in their faces... the way they walk and interact with others or with the troubles they have in school." She described driving a particular student home and "leav[ing] her outside, in a sleeveless top, because her mom didn't have an extra set of keys made." This nurse explained that when she asked, the student "said nobody was home because her mother had to work or go to school until late

and she didn't have a chance to find a sitter or to have an extra set of keys made up for her to let herself in."

This nurse also commented that "duh… it suddenly made sense to me at that point. [The student] is really a good kid. She was having problems with her teacher and school work, dressing and getting to school everyday because her mother was working, taking classes, going through a separation and trying to raise [the student]." The school nurse also described feeling "bad" and her "responsibility to put that in [the students] case file and to refer it to the principal and child protection."

Commenting on "substance abuse" and their "experimenting with sex," the school health care providers agreed "more and more students," "more than in even the recent past," "younger students," and "all students at younger ages" were "busy trying," "experimenting with," "trying different and more serious drugs," "petting," "kissing," and engaging in "intercourse" and "unprotected sexual activities." One health care provider described a student that "painted his nails white and he got his friends to paint their [nails] too so they could sniff 'white out,' laugh, fool authority and get high in school without their teachers knowing."

Other health care providers reported counseling students "usually after they tried" "alcohol," "marijuana," "nicotine," "cigarettes," "sleeping pills," "diet pills," "stimulants," "Ritalin," "caffeine," "stay awake pills," "amyl" and "butyl nitrate," "snappers and poppers." When asked to estimate what percentage of students in the district had "tried these substances," these health care providers indicated "less than 5 percent," "probably 5 percent or less" and that they were "not really sure" and "could not say in all cases for certain how many students we're talking about." These individuals

indicated "the district doesn't have the time or the resources to put that together in a single record for the district" and "each of the different nurses may have a different way for how they keep their records and follow up with students."

On the subject of the students' engagement in sexual activity and their sexual behaviors, the health providers volunteered that "as many as 8 to 10 percent," "8 percent," "5 to 7 percent" and "5 to 10 percent of students" in their schools had "tried," "experimented," "experimented with," "explored" and "acquired sexual experience" with a partner. These health care providers added "they aren't using protection," "most [students] do not practice intercourse safely," and that "access to condoms is not generally available for the [students] we see."

On the Preparation of Principals and School Administrators

Administrators

In relation to issues surrounding the delivery of health care to students, the seven principals and the preschool director indicated their learning came through "experience," "personal experience," "finding your way," "asking questions," "getting involved," "watching" and "talking with parents and colleagues." None of these individuals recalled participating in college courses or receiving training or formal instruction on health care delivery while enrolled in their administrator preparation programs.

These individuals explained that they "discussed," "read about," and "studied health" "on their own," "in their personal reading," "at home," "on my personal time," "as it related to my personal life… my kids and my family," in "special ed[ucation] seminars," "by asking questions," and "in different courses but only in passing." They also learned about health care issues "during IEP conferences," "if we had a school or

district emergency," "on a committee to hire a school nurse," and "on a need to know" basis.

On the subject of supervision of personnel, one administrator admitted knowing, previous to being hired, that the preschool director and building principals supervised school nurses and other health care staff. The remaining administrators indicated they "never really thought about it," "don't really think about the school nurse or her health assistant when you're just starting out," "probably should pay more attention to health care" and "had so much to learn and to keep up with that you don't really get too involved in what the nurse does until you have to."

According to district policy, these administrators are also responsible for evaluating the nurses, the psychologists and the social workers in their schools. When questioned about specific training for evaluating health care staff, these individuals explained during a focus group session that "probationary nurses must be evaluated at least once a year and continuing nurses at least once every three years." One of the administrators also commented that "we use a performance assessment checklist and are supposed to evaluate their skills in four areas."

A review of Raven's "School Nurse Performance Instrument" indicates they are evaluated using a likert scale. Administrators rate school nurses a "4" if they "exceed standards" and a "1" if they are "not satisfactory" in the areas of "management," "delivery of services," "collaboration with others" and "professional development." School psychologists and social workers are evaluated using the district's "teacher performance evaluation checklist" by school administrators while other health care providers,

including heath care assistants, are evaluated by school nurses without the use of a standard evaluation instrument.

When asked again about any specific training received, each of the administrators interviewed for this research indicated they had "not received training specifically designed for evaluating nurses, psychologists or social workers." These administrators also agreed that they "should get help," "more direction," "guidance" and "train[ing] on how to supervise and evaluate our nurses if we're expected to do that," and that they did not "remember," were "unsure," "couldn't be sure," were "unaware" and did "not know" of the required qualifications of school nurses and health care staff.

Health Care Providers

Not one of the school nurses, psychologists, social workers or the other health care providers included in this research could comment on the actual training and instruction that the principals and preschool director received in their preparation to become school administrators. Based upon what they "observed," "heard while talking with others" and "experienced," these individuals estimated that building administrators "had some," "probably got some," "maybe received some," and "had absolutely no training whatsoever."

These health care providers explained that "[administrators] don't really understand what we should be doing," "how we can help," "how to value, assess and evaluate health care services," and "how to take advantage and make the nurses and the others fit in." One nurse commented that "they use us to screen students for their shots, mostly at the start of the year, to follow up on dental and whether these kids need glasses, then it's bruises and bandages, cuts and coughs." Another indicated "[administrators]

want to help, mostly the students, but they just don't know how they can so they come around once in awhile, talk to a sick child and ask if we need anything." A third health care provider suggested "my [administrator] is great if I need anything or if a message has to go home, but I think he tries to stay out of the way, to let me do whatever."

When asked how they "should" be utilized, the nurses, psychologists, social workers and other health care providers recommended that they should be "teaching the students more," "teach more," "educate the students about taking care of their selves too" and "interacting with the students on a daily basis outside of the clinic." During focus group interviews, these individuals suggested that "providing health care today involves more than screening and treating students. It's like the schools never heard of prevention." Others agreed, commenting that "80 to 90 percent of what we see is preventable" and "teaching is the best medicine." One individual said:

> "It's so frustrating. I feel like we could be doing so much more. Educating the students in a regular classroom, learning about them and their family's needs. We could be talking to these students and their parents about what they eat, depression, alcohol, safe sex, seat belts, not using harmful drugs. Some of the kids you meet don't really care about who they are or what they're doing. They come late and some dropout of school and get in trouble. Those kids I believe can be helped. Right now, it's like the emergency room in the hospital. We mainly see the students when they're sick or when they're hurt or when someone decides that they should go see the nurse. It's like they're being taught in school you only go see the doctor or you only go to the hospital when you feel bad or when you're hurt or sick. That's not the right way to practice taking care of yourself. Good

health care maintenance is learned early in life. These students need to learn that they don't have to be sick. They could take steps to prevent illness and to take care of their health. I just wish the principals and the school district would know what their doing and that they should do something about it. Otherwise, it's the same thing everyday and we don't get anywhere with really helping these students."

Other health care providers concurred, indicating that administrators "don't truly appreciate what it means to care for the whole child it seems." These individuals stated "[the administration] only sees how the child is hurt on the outside. They don't seem to fully comprehend what we do" and "how we are trained to provide care." These individuals indicated they were knowledgeable of "conditions and factors that make learning difficult" including "amotivation," "sedentariness," "depression," "identity formation and identity crisis," "healthy and unhealthy behaviors for developing interpersonal relationships" and "health conditions leading to student underachievement."

These health care providers also recommended that administrators "come to us for ideas." They suggested that schools "should offer health awareness days," "health fairs where the students and teachers can meet doctors and nurses and learn about what they do," "health appreciation events when students learn to be excited about taking care of their bodies, their emotions and how to deal with the inner and outer pressures they face," and that students be allowed to "meet responsible people who could talk about training, endurance, physical training and having a positive outlook on life."

These individuals also suggested that administrators "make the nurses feel like they're a part of what the school does." They mentioned "invite us to faculty meetings

too," "talk with us about staff development," "introduce the nurses to the teachers and students," "make us more visible," "have an health information area where [the students and parents] can go for different information," "invite the [health care] staff to the classrooms and to parent conference days" and "share with us the teachers' schedules and what they're doing so we can be aware, plan with them, exchange ideas and help them teach the students."

On the subjects of supervision and evaluation, the nurses, psychologists, social workers and other health care providers indicated they were dissatisfied with existing district policies and procedures. These individuals favored "keeping [the principals and preschool director] as long as they go back to school [for additional training]," "learn more about health care delivery," "study more," "learn more about nursing and health care" and "learn about the full range of services available and how to make better use of what we do." They suggested that "as long as we are here working to provide care for students then the principal is the best person to be in charge." These providers explained that the building administration "is the boss," "makes the decisions," "is very very important," "sees the entire school," "is the best person to make the most of what we need and have to give," and that "[the administration] really has a bigger influence on increasing access and the health and future health of the students than we do."

These individuals also indicated that administrators "are very busy," "seem very busy," and that building administrators "are always playing catch up" and "have a lot to do." They explained that "[the administration] doesn't always get to evaluate us as much as they're supposed to," "seems to always evaluate us last," "are hurried and unable to

complete a full evaluation" and that the principals and preschool director "really don't have the time to do a comprehensive evaluation of the staff and health care setting." One of these health care providers also indicated that administrators "use a performance assessment checklist with a scale that doesn't measure anything and that's nearly impossible for them or even us to screw up on."

During separate interviews other health care providers described how the assessment checklist and evaluation procedures "emphasizes minimum standards," "scratch the surface," "is generic and probably not relevant," "is designed for evaluating teachers," "looks at the wrong things," "is embarrassing," "doesn't measure growth and progress," and "seems to deemphasize any kind of prevention, improvement or change." These health care providers also agreed that school administrators need "better training," "more training," "counseling," "on going development" and "assessment training" in the evaluation of school nurses and other health care staff.

Discussion

Research Question One: *What do Title 1 principals know and how do they respond to the health care problems experienced by students in their schools?*

"... you just don't realize how many students you meet when you're wiping noses and bandaging hands and knees."

Analyses of the data collected indicated the principals and preschool director were knowledgeable of the different types of health problems experienced by their students. These analyses also revealed that the school administrators interviewed had educational backgrounds and that their understanding of health care was gathered informally, over time, and on a need to know basis. Analyses also indicated that administrators'

descriptions of the health challenges experienced by students tended to focus on health problems that were overt and that occurred more often, and that their diagnoses and recollections did not include descriptions of students experiencing emotional or psychological distress. Administrators also did not refer to accidents, substance abuse or other risk taking behaviors as they were engaged in by students.

Administrators also chose to become involved in giving students medication, and in providing and securing the involvement of individuals from outside of the educational community in providing transportation, resources, monetary and needed health care support to students. They also called upon school health care providers when they perceived they were unprepared and that professional intervention was needed. Analyses also indicated that administrators assisted health care providers in following up on some of the health related challenges experienced by students, and that they were aware of policies regulating student participation in stressful activities and aware of procedures for reporting the absence of students from school and instruction.

Analyses of observations and descriptions of health care issues given by administrators also indicated they did not engage in discussions or initiate research related to investigating trends in health care problems experienced by their students. Analyses also revealed that lacking information on the range and patterns of health related problems experienced by students, that administrators tended to respond to the health care needs of students as they became apparent, and that they were unprepared and generally unable to develop relevant health care strategies that were preventative and educational in nature. Analyses similarly revealed that administrators did not initiate or encourage the developing of measures for assessing the availability of access to health

care for the students in their schools, and that they underutilized school personnel and health care staff in developing policies, procedures and programs for improving health care delivery and for increasing the knowledge of students on health care issues.

Analyses of the supervisory and evaluation practices used by school administrators also revealed that they relied on instrumentation and engaged in supervisory and evaluative practices that were generally inadequate and inappropriate for supporting and improving the overall quality of health care services delivered to students in their schools, and that they did not move to correct these problems. Administrators tended to define their responsibilities for safeguarding the health of students and health care procedures by deferring to the training, knowledge, experience and judgments of school nurses and other health care staff. They also demonstrated neither the interest nor the capacity for collaborating with school health care providers on improving supervisory and evaluative techniques and long-term health care delivery.

Research Question Two: *How and to what extent do administrator preparation programs enable principals to respond to the health care problems experienced by students?*

"...you learn about health care in special education meetings, by asking questions, and on a need to know basis. ...you don't really get too involved in what the nurse does until you have to."

Estimates on the quality and extent to which administrator preparation programs enabled principals to respond adequately to the health care problems experienced by their students are problematic to achieve and based almost entirely upon the accounts provided by the administrators included in this study. Nonetheless, analyses of their recollections

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and descriptions indicated that the administrators herein reported learning about health care delivery and health related issues through personal initiative and through their contacts with students, parents, school personnel and health care providers.

These administrators did not recall receiving instruction on the diagnoses, range, and severity of health problems experienced by students. Neither did they recall lessons on the delivery of health care services in public schools, on relevant health care related legislation, and on specific techniques for supervising and evaluating school nurses and other health care staff. Neither did all but one anticipate that they were responsible for supervising and evaluating school nurses and other health care providers prior to their administrative appointments.

Additional analyses of the behaviors of administrators indicated they routinely engaged in, and that they viewed health care issues and service delivery as critically important for improving the academic achievement and the development of their students. These analyses also revealed that administrators desired additional training on health care issues and heath care reform in public schools. Analyses also indicated that they wanted to help but that they felt unprepared, that they relied upon their best instincts and ambitions for helping students with health related problems, and that the administrators included in this study wanted to do more.

Research Question Three: *How do the policies and practices adopted in Title 1 schools support and place limitations on the delivery of health care to students with health related problems?*

"...teaching is the best medicine."

At first glance, the policies and practices adopted in the Title 1 schools studied, seem to favor maintaining the health problems experienced by low SES students as opposed to helping them to get well and to adopt practices that prevent them from being at risk of becoming sick and imperiled in the future. Involving inadequately prepared non health care administrators in overseeing health care delivery for example, not only poses questions related to ethics, accountability and to acceptable professional conduct and standards, but it may also appear to contribute to maintaining inadequate supervisory and evaluative approaches, to confused procedures for delivering medication to children, to limiting innovation in health care delivery in Title 1 schools, and to protecting health care delivery systems and approaches that maintain exorbitant health care provider to student ratios, that involve paraprofessionals in making diagnoses and providing service, and that are otherwise failing.

No. Analyses of the findings taken from this study indicate that health care delivery policies and practices in Title 1 schools seek neither to maintain nor to prevent Title 1 students from becoming sick. Instead, the policies and practices studied here cultivate ignorance and frustration and emotional and psychological distress. These approaches favor teaching students to visit the doctor "when you feel bad" or "when you're hurt" or "when you're really very sick." They return children with head lice to live in unsanitary conditions.

The approaches to health care delivery studied in this research also minimize opportunities to provide formal instruction, guidance and training, and in that way, contribute to placing students who engage in or are subjected to risk taking behaviors in harms way. They favor technology for counting days and the numbers of classes missed by students, but they ignore studying the nature of the health problems experienced and again they contribute to children routinely being sick in schools, and to their being weak and underdeveloped.

Yes. Let's count and collect and discard the uneaten apples and oranges, the spaghetti wrapped in aluminum foil. Better than to give it to a bunch of needy kids. And never mind developing procedures for assessing how many students have health insurance and regular contact with professionals in health care delivery. Be sure to forget that they face inner and outer pressures that are corrosive, and that they come and that they're poor and that they are Limited English Proficient. These aren't the students for whom health care delivery in schools is designed and intended. No, health care delivery in Title 1 schools may be more appropriate for supporting the health and the educational progress of non poor students who are more often in excellent health, who are less likely to experience short term restriction of activity due to acute health problems, who have fewer restricted activity days and who have fewer bed days and fewer days absent from school.

Conclusion

The range of issues limiting the healthy development and care of students in and out of Title 1 schools seems vast, multifarious and complicated to untangle. Developing and maintaining quality health care in public schools also seems problematic for the

principals, preschool director and the different health care providers included in this study. Nonetheless, these administrators seem aware of the numerous factors that contribute to students coming to school sick, poorly nourished and poorly fed. These administrators also seem to believe that it is partly their responsibility to ensure that their students eat well and that they enjoy good health in general.

Analyses of the data collected also indicate a difference in orientation exists for those who administer schools and for those who provide health care to students in those schools. Both groups understand that a fundamental relationship exists between a student's health and their capacity to excel in school. Both also seem to agree that given their lifestyles and needs, providing health care to students in Title 1 schools is unavoidable and essential. Where members from these two groups seem to depart is in their concept of what health care providers ought to do.

Administrators call upon nurses, psychologists, social workers and other health care staff to assist in making their schools run better. They ask for help in registering new and evaluating other students for placement in special education programs. They require that the health needs of students and teachers be identified when needed, and that health care staff maintain records, contact with the community and contact with the parents of students that are absent from school. Administrators also ask that members from the health care community provide special care for handicapped students, health counseling, help on the bus, and that school nurses, psychologists, social workers and others perform tasks as required to accomplish the mission, goals and objectives of the district.

School health care staff, on the other hand, long to get involved in delivering an educational benefit. They believe in schooling students on preventative measures for

preserving and maintaining their overall health. These individuals believe that learning how to take care of oneself is every bit as important as learning about other subjects in school. They also feel strongly about improving themselves, and about improving how they provide care to students in schools.

This study stands as an introduction to health care delivery in Title 1 schools. It introduces arguments for delivering health care to needy students in the public school setting, and it introduces figures on the current health status of children. This study also introduces information on a school-based model for health care delivery, and it introduces some of the inner and outer pressures that are influencing how health care is being delivered and experienced in a Title 1 school district. This study also introduces how administrators and health care providers feel and respond to the health problems experienced by their students, and how they interact.

Analyses of findings taken from this research indicate that administrators and health care staff are likely to continue to experience a call for health care services in their schools well into the future. Analyses also suggest that principals are inadequately prepared to initiate health care service reform. This paper serves as an introduction to the numerous ideas listed earlier. It also serves to introduce health care delivery to the discourse on administrator preparation, and to introduce educational policy makers, practitioners and theorists to the business that school nurses and other health care providers engage in in Title 1 schools.

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